CALIFORNIA

PacifiCare®

COBRA Election Form

Important: Please complete all sections. This form cannot be processed if information is incomplete.

PacifiCare ID #

When appropriate, attach a completed PacifiCare Enrollment Application to this Election Form

Employer Name	Group Number

COBRA Information (To be completed by employer)

Member/Enrollee Last Name	First	M.I.

Is the member/enrollee a current PacifiCare member/enrollee?

☐ Yes Please enter the PacifiCare ID Number in the box in the upper right of this form and complete Sections A and B of this form.

☐ No Please complete Section A only of this form and attach a completed PacifiCare enrollment form.

(If this new enrollment is not occurring during open enrollment, please attach details of the applicant's eligibility for COBRA enrollment.)

SECTION A – Qualifying Event (Please specify)

☐ Termination or reduction in hours of employment
☐ Death of employee
☐ Divorce or legal separation
☐ Loss of coverage due to employee Medicare entitlement
☐ Dependent ceasing to qualify under the plan
☐ Employer bankruptcy under Title II

Qualifying Event Date	Last Date of Coverage by Employer	COBRA Start Date	COBRA End Date

SECTION B – List of Continuing PacifiCare Members/Enrollees only

Please complete for continuing members (beneficiaries) who will be continuing coverage. If applicable, include employee.

						HMO/POS ONLY
1	Self	Last Name	Social Security Number - -	Street Address		Primary Care Physician Name
	Sex M or F	First Name M.I.	Date of Birth (Month - Day - Year) - -	City State ZIP		Medical Group Name
2	Spouse	Last Name	Social Security Number - -	Street Address		Primary Care Physician Name
	Sex M or F	First Name M.I.	Date of Birth (Month - Day - Year) - -	City State ZIP		Medical Group Name
3	Relationship	Last Name	Social Security Number - -	Street Address		Primary Care Physician Name
	Sex M or F	First Name M.I.	Date of Birth (Month - Day - Year) - -	City State ZIP		Medical Group Name
4	Relationship	Last Name	Social Security Number - -	Street Address		Primary Care Physician Name
	Sex M or F	First Name M.I.	Date of Birth (Month - Day - Year) - -	City State ZIP		Medical Group Name
5	Relationship	Last Name	Social Security Number - -	Street Address		Primary Care Physician Name
	Sex M or F	First Name M.I.	Date of Birth (Month - Day - Year) - -	City State ZIP		Medical Group Name

Benefit Coordination/Other Insurance Carrier Information

1. Does anyone listed have other health insurance? ☐ Yes ☐ No If yes, complete section below.
2. Is anyone listed permanently disabled? ☐ Yes ☐ No Name _____ Date disability began _____ (M - D - Y)
3. Is anyone listed eligible for Medicare? ☐ Yes ☐ No Name _____ Medicare ID# _____

NAME	INSURANCE COMPANY NAME	POLICY NO. & EFFECTIVE DATE	OTHER EMPLOYER NAME & ADDRESS

Member/Enrollee Signature	*Date*	*Employer Signature*	*Date*

PacifiCare SignatureValue℠ (HMO) and PacifiCare SignaturePOS℠:
P.O. Box 6006, MS CY24-515
Cypress, CA 90630

PacifiCare SignatureOptions℠ (PPO)*, PacifiCare SignatureIndependence℠ (Indemnity)* and PacifiCare SignatureFreedom℠ (SDHP)* :
P.O. Box 6098
Cypress, CA 90630

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***Underwritten by PacifiCare Life and Health Insurance Company**

DISTRIBUTION: EMPLOYER—ORIGINAL PACIFICARE—CANARY EMPLOYEE—PINK